Agenda

The Washington Preferred Drug List: Cost Analysis and Decision Making Process

04/08/2005
10:00 AM – 12:00 PM
John A. Cherberg Building
Capital Campus, Olympia
Senate Hearing Room 4

Type of meeting:	Informational Session
Facilitator:	Jeff Graham, M.D. Health Care Authority, Prescription Drug Program Consultant
Attendees:	Open to the Public

Agenda topics

Welcome	Jeff Graham, M.D.
Preferred Drug List Decision Process	Tim Barclay Milliman USA
Q & A Session	Stakeholders

Resource persons:	Erika Clayton Health Care Authority, Prescription Drug Program Coordinator
Special notes:	If you are a person with a disability and need a reasonable accommodation or have questions, please call Erika Clayton at (206) 521-2027 or E mail at pdp@hca.wa.gov. An accessibility map of the Washington State Capital Campus containing driving directions and parking alternatives is available online at http://www.leg.wa.gov/common/maps/campusmap.htm **Persons with Disabilities:** Those needing auxiliary aids or services for purposes of attending hearings or participating in other legislative activities should call the Senate at (360) 786-7400 for further information. TTY 1-800-635-9993.

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Washington Prescription Drug Program

Preferred Drug Cost Analysis

Data

- 6-month history provided by MAA, L&I, UMP including:
  - NDC
  - Drug name
  - Units dispensed
  - Days supplied
  - Scripts filled
  - Current ingredient cost (including MAA MAC pricing)
  - Most recent federal and supplemental rebates

Computation of Average Daily Cost (ADC)

- Net Cost Per Unit = Ingredient Cost Per Unit – Rebates Per Unit for MAA
- Total Net Cost by NDC = Units Dispensed x Net Cost Per Unit
- Total Net Cost by Drug = sum of Net Costs by NDC for this Drug – copays for UMP
- ADC = Total Net Cost by Drug / sum of days supplied for this Drug
- Days Supply Weighted (DSW) composite ADC by Drug computed for the three Agencies

Status Code Assignments

1. Required for PDL inclusion - usually the result of P&T committee direction
2. Eligible for PDL inclusion - generally generics and non-MAC brands
3. Not eligible for PDL - brands subject to MAC pricing
4. Not eligible for PDL - excluded from eligibility by P&T committee
5. Required for PDL inclusion – P&T committee selection for specific conditions

Exhibit 1

Average Daily Cost Rankings

- Lowest tri-agency DSW-ADC normalized to 1.000
- All other DSW-ADC values proportionately normalized
- Drugs ranked first by Status, then by DSW-ADC – both in ascending order
- Exhibit also displays annualized Days Supplied by drug

Exhibit 2

Savings Estimates by Number of Drugs Included on the PDL

- First line includes all Status 1 and Status 5 drugs
- Each subsequent line adds the next drug from Exhibit 1
- Savings computed based on assumed shifting percentage
- Savings are net of administrative costs for MAA and L&I

Questions

- How are supplemental rebates considered when they may vary by level of exclusivity?
- Once a shifting percentage is determined, how is utilization allocated to the PDL drugs?
- How would we deal with a new generic drug with little or no historical utilization?
- Are there exceptions to the rules discussed in this presentation?

Washington Prescription Drug Program's
Preferred Drug Cost Analysis and Selection Process
(November 1, 2004)

I. Purpose:

To establish a consistent methodology for the Uniform Medical Plan, Medical Assistance Administration and Labor & Industries (the agencies) to use when selecting a preferred drug within a therapeutic class.

II. Scope:

This methodology applies to selection of preferred drugs for the drug classes to be included on the State of Washington Preferred Drug List (PDL). Drugs purchased through managed care contracts are not included in the analysis and are not within the scope of this document.

III. Background:

RCW 70.14.050 authorizes the agencies to collectively determine the preferred drug(s) in a class based on the scientific evidence of efficacy and safety. For drugs with similar efficacy and safety, but with no differences when considered in special populations, the agencies have developed the following process that determines which drug(s) in a class are the lowest net costs to the state of Washington.

IV. Determining the Average Daily Cost

1) Each agency will keep a record of the average daily cost (ADC) (see formula below) and drug "unit" utilization for each drug in a class.

a. The third party will compute the ADC for each drug in the PDL class using the following steps:

b. Each state agency will provide the following data for each National Drug Code (NDC):
   i. NDC
   ii. Drug name
   iii. Units dispensed
   iv. Per unit ingredient price
   v. Per unit federal and state rebates (proprietary and confidential)
   vi. Days supplied
   vii. Although not needed for the ADC calculation, each agency will also provide the number of scripts written by NDC for the computation of administrative costs and copay values described below.

c. Total Net Cost by NDC is computed as Units x (Per Unit Ingredient Price – Per Unit Rebates).

d. Total Net Cost by candidate PDL drug is computed as the sum of total net costs by NDC for all NDCs for that PDL drug.

e. Total Days Supplied by candidate PDL drug is computed as the sum of all days supplied by NDC for all NDCs for that PDL drug.

f. ADC for each candidate PDL drug is computed as total net cost divided by total days supplied.

- The prices used to compute the ADC will be the most recent available, for example MAA prices are updated on a weekly basis.

- Utilization information will be based on the most recent 12-24 months of utilization data available. After the initial PDL determinations are made, updates will be based on the most recent available calendar quarter of data.

- Agency staff recognizes that historical utilization data may not reflect future trends for many reasons, among them significant price changes, impact on the market of new entries within a particular or related category of drug, and patent status changes. Agency staff also recognizes that historical information, absent other information, is the best predictor of future utilization given that actuarial and other technical adjustments are made as required.

- Utilization data for a new generic will use the associated brand's utilization as a proxy for the generic equivalent in PDL selection and potential net savings calculations.

- Utilization data will be used in the recommendation process for two basic purposes: First, to model relative shares of individual NDC demand within each drug; e.g. the use of 5mg tabs rather than 20mg tabs of a particular medication. Second, the data will provide an initial basis to estimate savings to the State under various scenarios.

2) MAA's average daily cost calculations for brand name (and certain generic) drugs include:

- State and federal rebate amounts paid for the drug(s); and

- A Maximum Allowable Cost (MAC) which may be set for generic and brand drug(s). MAC means the maximum amount that the MAA pays for a specific dosage form and strength of a multiple-source drug product..

- The following principles will guide MAA's ranking of a drug that has a MAC (Automated Maximum Allowable Cost (AMAC), State Maximum Allowable Cost "SMAC", or Federal Upper Limit "FUL"):

- Generics with or without a MAC will be included in Exhibit 1 and 2 when it will encourage equally effective and less costly utilization;

- Brand name drugs with a MAC will be included in Exhibit 1 however not included in the PDL selection when it will negatively affect the MAC program by increasing the number of MAC waivers.

- MAA – Division of Medicaid Management (DMM) pharmacy staff will announce future PDL classes to MAA – Division of Business and Finance (DBF) pharmacy staff in advance of the PDL selection in order to allow them to research and set state MAC prices where possible.

3) MAA, UMP, and L&I will send their respective average daily cost information to an agreed upon third party to maintain contractually required unit pricing confidentiality for analysis.

IV. Determining the Lowest Net Cost to the State

1) The third party will model administrative (Prior Authorization (PA)) costs, Co-Payments (where applicable), substitution and intra-agency pricing differentials for each drug.

a. The administrative cost assumptions and methodology are as follows:

   For MAA and L&I, PA administrative costs have been estimated at $15 and $20 per call, respectively. These estimates are based on analysis performed by MAA and vendor pricing provided by L&I. Using actual call frequencies and prescription counts for the period April 2004 – July 2004 provided by MAA, the third party correlated the PA frequency to the number of non-preferred scripts (where the number of PA calls was approximately 20% of the number of non-preferred scripts). Administrative costs are estimated as the number of non-preferred scripts multiplied by 20% and then multiplied by the per call charge.

   No administrative costs are included for UMP.

b. The Co-Payment assumptions and methodology is as follows:

   ADC amounts are reduced by modeled co-payments. For each NDC, UMP provided an assumption of retail or mail order, from which it was assumed that retail drugs were prescribed in a 30 day supply and mail order drugs were prescribed in a 90 day supply. The Total Days Supplied was also provided, which combined with the days prescribed assumption, allowed for the estimation of the number of scripts written. The actual number of scripts written will be included in the data extract sent to the third party. Co-payment rules by tier and by retail/mail order were then applied to each drug.

   No co-payment reductions were applied to MAA or L&I.

c. The substitution and intra-agency pricing differential impacts are as follows:

For each PDL scenario, those non-preferred drugs that shift to preferred drugs are assumed to do so in proportion to the relative historical utilization of preferred drugs separately for each agency. For MAA, the percentage of non-preferred drugs assumed to shift to preferred drugs in the savings estimate is based on recent historical levels of preferred drug utilization in the four classes with such history. The two classes for which the PDL is new (skeletal muscle relaxants and urinary incontinence drugs) have assumed a 70% migration of non-preferred to preferred drugs (a percentage slightly better than long-acting opioids). For Estrogens, PPIs and Statins a 90% migration assumption has been used.

Substitution for UMP assumes no movement of non-preferred generics and 50% movement of non-preferred brand name drugs.

Substitution for L&I is assumed to mimic MAA.

Intra-agency pricing differentials are considered in the model as drugs in each class are ranked according to the composite average cost for all three agencies combined. This composite ADC uses historical utilization by agency as weights in this computation.

2) The third party will incorporate these impacts into the ADC to construct an adjusted or net cost ADC for each drug, for each agency. The assumptions and methodology for the adjustment is as follows:

The model considers the co-payment adjusted UMP expenses as part of the initial ranking of drugs by class. Administrative costs and substitution rates are considered as part of the savings estimates associated with each PDL scenario by drug class.

3) The third party will, for each drug class and agency, rank order the ADC for each drug using a weighting relative to the lowest cost drug in a class, again assuring that federal and supplemental rebates are not disclosed.

Formula for weighting: Relative weight (RW) = (ADC for a Drug) / (ADC lowest drug)

4) The results will be arrayed from lowest cost to highest cost subject to the following categorical criteria. Within each therapeutic class, each drug will have a PDL eligibility status defined as one of the following five options:

1. Required for inclusion on the preferred drug list. In most cases this situation is the direct result of a P&T Committee decision (e.g. Lipitor®). It can also result from linkage to other contractual arrangements that make it financially impractical to offer any PDL that excludes the drug (e.g. Imitrex®).

2. Eligible for PDL inclusion. Generics and non-S-MAC brands are generally eligible for PDL inclusion (e.g. lovastatin).

3. Brands subject to MAC are identified and assumed not eligible for PDL inclusion (e.g. Mevacor®).

4. Excluded Drugs. Drugs identified by the P&T Committee as being excluded from eligibility for the PDL (e.g. Crestor®). These drugs are expected to have a very selective PA and minimal utilization.

5. P&T Committee selected drugs for specific medical conditions. Similar to Status 1 drugs in that the P&T Committee has directed their inclusion. However, these drugs differ in the model because they address a specific medical condition (e.g. Pravachol®). Therefore, the model assumes their inclusion in the PDL but excludes them from any utilization shifting assumptions as part of the savings estimates.

This status identifier (1-5) will be provided by MAA and is included in Exhibit I for each drug, which ranks drugs by status and the all agency combined ADC.

5) The results will be displayed in a format similar to the example below (See table #1)

Table 1: Average Daily Costs Rankings

Drug Class/Status	Average Daily Agency Costs Rankings*				Annualized Days Supplied			
	MAA	UMP	L&I	Combined	MAA	UMP	L&I	Combined
Drug/ 1								
Drug/ 2								
Drug/ etc.								

* Exclusive of dispensing fees and pharmacy charges; inclusive of federal and state rebates. The ADC calculations include UMP co-payments.

IV. Decision Methodology to Choose Preferred Drugs in a Class

While having a single preferred drug in a class will usually result in the lowest net cost to the state, other issues related to agency business needs, clinical and P&T Committee requests, WAC's and RCW may require increasing the number of drugs in a preferred class.

Agency staff recognizes that these constraints, clinical information and common sense will require that adjustments be made on a drug by drug basis. The following presents the framework for the final determination:

All Medications on the PDL must:

- Be among the categories of medications that have been reviewed by the Oregon Health & Sciences University Drug Effectiveness Review Project that Washington participates in.
- Be ranked consistent with any direction given by the Washington State P & T Committee.
- Exclude brands with generics that have an MAC for the calculations of ADC.

For all drugs within a class that meet the above initial selection requirements the agency staff shall use the tabular data described above and two summary exhibits created by the third party to assist in the decision process. Those exhibits are as follows:

- Exhibit I will display the ranking of medications using the RW- ADC price of each medication and the historical utilization for that medication.

  In situations where new drugs or other changes will impact future utilization those shall be noted and any adjustments documented.

  In situations were the P & T Committee has made specific recommendations for specific drug(s), they will be added to the top of the list.

- Exhibit II will display the results of a savings impact analysis by conducting a savings impact analysis using the adjusted ADCs with offsets for administrative costs.

  Exhibit II shows the agency savings, administrative costs and net savings to the state by adding an additional drug in order from the lowest to the highest net cost generic. Subtracting the agency administrative costs from the gross agency savings results in net agency savings. Combining each agency determines net state savings. The drug(s) resulting in the highest net state savings is moved forward for PDL Selection.

  In situations where new drugs or other changes will impact future utilization those shall be noted and any adjustments documented based on brand equivalent utilizations.

  The third party shall report saving impacts, again assuring unit cost confidentiality.

Table 2: Savings Relative to Increasing Access to Generic/Brand and Switching

	SAVINGS						
Drug	State	Gross Savings			–Net Savings		
	WA	MAA	UMP	L&I	MAA	UMP	L&I
Drug							
Drug							
Drug							
Drug							

* Savings assume the difference between shifting a percentage non-preferred drugs to preferred

Agency staff deliberations will include reviews of:

- The data presented.
- The methodologies and assumptions used.
- Buying access assumptions (e.g. % brand/generic).
- Consistency with DUR/P&T/Clinical requirements.

Agency staff shall make Preferred Drug recommendations to agency heads using information from these deliberations to determine the lowest net cost to the State.

Agency heads shall determine the preferred drug(s) in a category based on the PDL agency staff analysis and recommendations.

All Preferred Drug determinations shall be reviewed at least annually by the P & T Committee.

Prescription Drug Program
Agency Staff Drug Class Analysis and Recommendations:
Proton Pump Inhibitor Drug Class 10/29/2004

Drugs in Class

Generic	Brand
esomeprazole	Nexium®
lansoprazole capsule, powder	Prevacid®
lansoprazole solutab	Prevacid SoluTab®
omeprazole capsules	Prilosec®
omeprazole tablets	Prilosec OTC®
pantoprazole	Protonix®
rabeprazole	Aciphex®

P&T Committee recommendations

After considering the evidence of safety, efficacy and special populations, I move that rabeprozole, omeprazole, lansoprazole, pantoprazole, and esomeprazole are safe, efficacious and have no differences in adverse events in special populations. They can be subject to therapeutic interchange in the Washington preferred drug list. A pediatric formulation needs to be included on the Washington Preferred Drug List. [Reese, Bray 2nd, passed unanimous, White absent.]

Cost Analysis

Status	PPIs	Days Supply*				Relative Daily Cost -Net Copays
	Drugs	MAA	UMP	L&I	Combined	Combined
2	PRILOSEC OTC	2,601,404	86,266	22,744	2,710,414	1.00
2	PREVACID CAPSULE	2,471,202	306,030	35,222	2,812,454	1.59
2	PROTONIX	4,799,606	519,614	29,976	5,349,196	2.00
2	ACIPHEX	0	147,072	7,450	154,522	3.38
2	NEXIUM	992,210	490,948	30,058	1,513,216	4.03
2	OMEPRAZOLE RX	163,612	683,982	16,372	863,966	4.50
3	PRILOSEC	68,408	59,724	6,554	134,686	7.63
5	PREVACID POWDER	0	1,640	0	1,640	4.08
5	PREVACID SOLUTAB	56,270	1,102	0	57,372	4.64
	Total - PPIs	*11,152,712*	*2,296,378*	*148,376*	*13,597,466*	

*** Days Supply derived from February 2004 – July 2004 experience, annualized**

Agency Staff recommendations

After reviewing P&T recommendations and conducting a cost analysis the staff recommends the following drugs to be preferred on the Washington PDL:

omeprazole tablets (Prilosec OTC ®)
lansoprazole tablets (Prevacid Solutab®)*
lansoprazole capsules (Prevacid®)
lansoprazole powder (Prevacid®)*

* **subject to expedited prior authorization for special populations (pediatric/swallowing difficulties).**

KEY TO DRUG STATUS NUMBERS

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